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Nos. 93-1408, 93-1414 and 93-1415

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In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner,

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, NATIONAL LEAGUE OF CITIES, AND U.S. CONFERENCE OF MAYORS, JOINED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The question presented is whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to an Employee Retirement Income Security Act (ERISA) plan, are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

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INTEREST OF THE *AMICI CURIAE*

Amici, organizations whose members include state, county, and municipal governments and officials throughout the United States, have a compelling interest in legal issues that affect state and local governments. They have a special responsibility to ensure that the States and their political subdivisions have adequate authority to control health care costs and to expand access to health insurance. Given the national government's inability, for more than twenty years, to adopt comprehensive health care reforms, it is crucial that *amici* retain the latitude to devise solutions for our nation's health care problems. New York imposed surcharges on hospital rates to spread costs and to promote the availability of health care coverage. The court of appeals' determination that these state rate regulations are preempted will sharply limit the ability of New York and other States "to try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J. dissenting). *Amici* accordingly submit this brief to assist the Court in its resolution of this case.[1]

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[1] The parties have consented to the filing of this brief *amicus curiae*. Letters indicating their consent have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

1. Section 514(a) of ERISA expressly preempts state laws "relate[d] to any employee benefit plan." 29 U.S.C. § 1144(a). Section 514(a) does not, however, reflect an unambiguous intent to preempt state regulation of health care. The statutory language does not on its face establish the extent to which national power to protect employee benefit plans displaces the States' traditional power to regulate public health. The court of appeals' determination that state hospital rate regulations are preempted under section 514(a) is inconsistent with the presumption against preemption of the States' police powers, and it extends the preemptive effect of the statute far beyond the bounds intended by Congress.

The presumption against preemption promotes the important policy of avoiding unintended intrusions on state authority by requiring that Congress express a "clear and manifest purpose" to preempt the States' police powers. *See CSX Transportation, Inc. v. Easterwood*, 113 S. Ct. 1732, 1737 (1993); *Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992). This presumption applies fully to the interpretation of the scope of an express preemption provision like section 514(a). The court of appeals erred in holding that state hospital rate regulations are preempted under section 514(a). Congress did not have a "clear and manifest purpose" to supersede the States' traditional power to regulate health care providers.

2. The court of appeals' holding that New York's hospital rate regulations are preempted under section 514(a) because they "substantially" or "significantly" increase costs of providing health care services for ERISA plan beneficiaries is an unwarranted limitation of the States' traditional power to regulate health care. The court of appeals' preemption standard deprives the States of the power to explore rate regulation as a means of controlling costs, and it threatens many other important state health care initiatives. Federal courts, for example,

have already invoked the decision of the court of appeals to preempt state taxes on health care providers. *NYSA-ILA Med. & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994), *petition for cert. filed*, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745); *New England Health Care Employees' Union, District 1199 v. Mount Sinai Hosp.*, 846 F. Supp. 190, 196 (D. Conn. 1994), *app. pending*, Nos. 94-7264, 94-7906 (2d Cir.). The court of appeals' unduly broad interpretation of the preemptive reach of section 514(a) leaves important health care matters ungovernable by the States and ungoverned at the national level.

ARGUMENT

I. THE COURT OF APPEALS' CONSTRUCTION OF SECTION 514(a) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PREEMPTION OF TRADITIONAL STATE POLICE POWERS

A. The Presumption Against Superseding State Police Power Regulations Applies To The Interpretation Of Express Preemption Provisions Like Section 514(a)

In section 514 of ERISA, 29 U.S.C. § 1144, Congress explicitly allocated regulatory authority over employee benefit plans between the national government and the States. However, the relevant provisions of this section "are not a model of legislative drafting." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)). Section 514(a) is an express preemption clause which is "conspicuous for its breadth" and "establishes as an area of exclusive federal concern the subject matter of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp.*, 498 U.S. at 58 (quoting 29 U.S.C. § 1144(a)). This express preemption provision is qualified by a "savings clause" that restores the States' power to enforce laws

that "regulat[e] insurance," 29 U.S.C. § 1144(b)(2)(A), except as in turn further qualified by a "deemer clause." Under the deemer clause, an employee benefit plan regulated by ERISA is not "deemed" an insurer subject to state insurance regulation.[2] 29 U.S.C. § 1144(b)(2)(B); *FMC Corp.*, 498 U.S. at 58.

Although this Court has developed a specialized body of law interpreting and applying section 514,[3] nothing in ERISA alters traditional preemption analysis. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 114 S. Ct. 517, 526 (1993). The rules that courts have developed in interpreting section 514, like other bodies of specialized preemption case law, must be understood as elaborations of traditional preemption principles. *See Hawaiian Airlines v. Norris*, 114 S. Ct. 2239, 2243, 2247 n.6 (1994); *Buildings & Trades Council v. Associated Builders*, 113 S. Ct. 1190, 1194 (1993) (both recognizing that particularized labor law preemption doctrines must be viewed against background of basic preemption principles).

Congressional intent is, of course, the key to any determination that state law is supplanted by federal law. *Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597,

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[2] In addition to these three provisions, other subsections also allocate authority between the States and the national government. *See, e.g.*, 29 U.S.C. § 1144(b)(4) (saving generally applicable state criminal laws from preemption under subsection (a)).

[3] *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 114 S. Ct. 517 (1993); *District of Columbia v. Greater Washington Bd. of Trade*, 113 S.Ct. 580 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp.*, 498 U.S. 52; *Mackey v. Lanier Collection Agency and Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life*, 471 U.S. 724; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Franchise Tax Bd. v. Construction Laborers' Vacation Trust*, 463 U.S. 1 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

604-05 (1991); *see also Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978); *Retail Clerks Int'l Ass'n, Local 1625 v. Schermerhorn*, 375 U.S. 96, 103 (1963). Congress' intent to supersede state law may be stated expressly in statutory terms or it may be implicit in the decision to occupy a particular field of regulation.[4] *Wisconsin Public Intervenor*, 501 U.S. at 604-05. Whether Congress' intent is explicit or implicit, the Court starts with a presumption against preemption of the States' historic police powers. Federal law thus will not supersede state law unless that result is " 'the clear and manifest purpose of Congress.' " *Id.* at 605 (*quoting Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Indeed, in two recent cases, this Court has construed express preemption provisions narrowly in light of the presumption against preemption of the States' police powers.[5] In *Cipollone v. Liggett Group, Inc.*, Justice Stevens noted that the "strong presumption" against preemption of state police powers requires a "narrow" construction of an express preemption provision. 112 S. Ct. 2608, 2618, 2621 (1992). Subsequently, in *CSX Transp., Inc. v. Easterwood*, this Court emphasized that the construction of express preemption provisions in light of the presump-

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[4] Preemption may also occur in a third way, "to the extent that state and federal law actually conflict." *Wisconsin Public Intervenor*, 501 U.S. at 605.

[5] Narrow construction of an express preemption provision in light of the presumption against preemption is consistent with the familiar principle that congressional intrusions on state authority are construed narrowly. *See, e.g., Will v. Michigan Dept. of State Police*, 491 U.S. 58, 65 (1989) (clear statement required to subject States to damages suits in state courts); *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985) (Congress must make its intent to abrogate State's Eleventh Amendment immunity "unmistakably clear in the language of the statute"); *Pennhurst State School v. Halderman*, 451 U.S. 1, 16 (1981) (condition of federal grant imposing costs on States must be stated clearly). *Cf. United States v. Bass*, 404 U.S. 336, 349 (1971) (federal criminal statutes construed narrowly to avoid displacing state power).

tion against superseding state law rests on "the interest of avoiding unintended encroachment on the authority of the States." 113 S. Ct. 1732, 1737 (1993). The Court also restated its exacting standard for preemption: "preemption will not lie unless it is 'the clear and manifest purpose of Congress.'" *Id.* (*quoting Rice*, 331 U.S. at 230).

These basic preemption principles apply with full force here. Congressional intent is the key to determining whether a state law is preempted by ERISA. *See, e.g., Ingersoll-Rand*, 498 U.S. at 137-38; *FMC Corp.*, 498 U.S. at 56-57. In interpreting the language of ERISA's express preemption provision and the insurance saving clause, this Court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*, 471 U.S. at 740; *see also Alessi*, 451 U.S. at 522. Under the standard employed in *Cipollone* and *CSX Transp.*, the narrow question in this case is whether Congress had a "clear and manifest purpose" to preempt New York's surcharges on hospital rates.

B. Although The Language Of An Express Preemption Provision Is The Best Evidence of Congress' Intent, The Presumption Against Superseding State Law Determines The Outer Limits Of Preemption

Analysis of the preemptive effect of section 514 "'begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.'" *Metropolitan Life*, 471 U.S. at 740 (*quoting Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)). If "Congress' command is explicitly stated in the statute's language," preemption of state law is compulsory to the extent of that statement. *Shaw*, 463 U.S. at 95 (internal quotations and citations omitted). When a statute contains an express preemption clause like section 514(a), "the task of statutory construction must in the first instance focus on the plain wording of the clause, which

necessarily contains the best evidence of Congress' preemptive intent." *CSX*, 113 S. Ct. at 1737; *see also Cipollone*, 112 S. Ct. at 2618 (preemptive scope governed by express language).

This Court, focusing on the language of the express preemption, insurance saving, and deemer clauses of section 514, has created a large body of ERISA preemption case law. In particular, the Court has construed section 514(a) broadly and has held repeatedly that "ERISA preempts any state law that refers to or has a connection with covered benefit plans." *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 (collecting cases). This broad reading of section 514 effectuates Congress' purpose of ensuring a uniform body of benefits law and "minimiz[ing] the administrative and financial burdens of complying with conflicting directives . . . ." *Ingersoll-Rand*, 498 U.S. at 142.

Although the Court has interpreted section 514(a) broadly, ERISA preemption is not without limits. Certain generally applicable state laws are not preempted. *See, e.g., Mackey*, 486 U.S. at 830-41 (garnishment law); *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. Moreover, as a general matter, the Court has also recognized that section 514(a) does not preempt state regulations that have only a "tenuous, remote, or peripheral" effect on employee benefit plans. *Gr. Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1; *Shaw*, 463 U.S. at 100 n.21; *see also Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2040 (1992) (express preemption of state laws "relating to" subject matter of Airline Deregulation Act does not extend to laws that affect the subject of the federal statute in a tenuous, remote, or peripheral manner). Thus, notwithstanding the explicit preemptive language of section 514(a), it does not unambiguously require preemption of all state laws that can in any sense be said to be "relate[d] to" an employee benefit plan governed by ERISA.

The presumption against preemption does not call into question either the central importance of the language of section 514(a) or this Court's judgments giving it broad preemptive effect. Nonetheless, because section 514(a) does not unambiguously call for preemption in all circumstances, the presumption against preemption plays a significant role in determining the extent to which state law is preempted.

In *Cipollone*, seven members of this Court agreed that an express preemption provision must be construed narrowly in light of the strong presumption against preemption. *See* 112 S. Ct. at 2618, 2621. Justice Blackmun, joined by Justices Kennedy and Souter, wrote separately to explain why the presumption against preemption applies fully to the construction of an express preemption provision. *See id.* at 2625-32 (Blackmun, J., concurring in part and dissenting in part). Where Congress has spoken directly, albeit ambiguously, to the issue of preemption, "the question is not *whether* Congress intended to pre-empt state regulation, but to what *extent*." *Id.* at 2626 (Blackmun, J., concurring in part and dissenting in part). In determining the extent of preemption, the presumption against preemption means that in the absence of unambiguous evidence, the Court will not "infer a scope of preemption beyond that which clearly is mandated by Congress' language." *Id.* (footnote omitted).

In short, the presumption against preemption of traditional state police powers guides the Court's determination of "borderline" preemption questions where it cannot be said that the express preemptive language of section 514(a) unambiguously dictates supplanting state law. *See Shaw*, 463 U.S. at 100 n.21. It helps determine whether the outer limits of ERISA preemption have been exceeded.

C. Congress Did Not Have A Clear And Manifest Purpose To Supersede The States' Traditional Power To Regulate Health Care Providers

The presumption against preemption of traditional state police power regulations provides important guidance in determining the scope of an express preemption provision where, as in this case, explicit statutory language simply does not address the question whether Congress intended to displace the States' power to regulate the delivery of health care. Congress did devote "considerable attention to the question of preemption," and Congress did adopt in section 514 a somewhat opaque set of provisions explicitly allocating power between the national government and the States. *Hewlett Packard Co. v. Barnes*, 425 F. Supp. 1294, 1298 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978). Congress, however, did not establish in the express terms of section 514(a) the extent to which national power to protect employee benefit plans displaces state power to regulate public health. *See Hewlett Packard*, 425 F. Supp. at 1298-1300 (analyzing legislative history of section 514(a)).

Congress focused on pension benefit plans in drafting ERISA and devoted little attention to welfare benefit plans. *See* D.M. Fox & D.C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. Health Politics, Policy and Law, 239, 240-44 (1989). Nonetheless, section 514(a) is drafted in broad terms that apply to both employee pension benefit plans and employee welfare benefit plans. *See* 29 U.S.C. § 1144(a); *id.* § 1002(3). Because employee welfare plans are defined to include health care plans, *see* 29 U.S.C. § 1002(1), the Court has given full effect to the language of section 514(a) and held that States cannot regulate directly the terms and conditions of employee health plans or require employers to offer or pay for health benefits. *Metropolitan Life*, 471 U.S. at 739; *cf. Shaw*, 463 U.S. at

96-100. *See also Standard Oil Co. v. Agsalud*, 633 F.2d 760, 765-66 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981).

Nothing in the statutory language, however, suggests any purpose to displace the States' traditional power to regulate health care. There is simply no evidence that Congress, in determining the preemptive effect of ERISA, considered state health care rate regulation—much less the effect, if any, of such rate regulation on any type of employee welfare plans. *See Hewlett Packard*, 425 F. Supp. at 1298-1300 (analyzing the legislative history of section 514(a)). The statute illustrates Congress' preoccupation with pension plan reform and regulation.[6] Any inference that Congress intended section 514(a) to prohibit state health care regulation is far-fetched, especially because Congress did not consider any substantive federal regulation of health care plans and did not make any provision for substantive federal regulation of state health care providers to be substituted for preempted state regulation. M. Bobinski, *Unhealthy Federalism: Barriers To Increasing Health Care Access For The Uninsured*, 24 U.C. Davis L. Rev. 255, 274-77 (1990); *see* Fox & Schaffer, 14 J. Health Politics, Policy & Law at 240.

The New York hospital rate regulations at issue in this case are designed to control hospital costs and to promote availability of health care coverage. Pet. App. 7-8. These regulations are undoubtedly a legitimate exercise of the State's power to regulate public health and safety. *See Hillsborough County v. Automated Medical Lab., Inc.*, 471 U.S. 707, 715, 719 (1985). There is no evidence that it was the "clear and manifest purpose" of Congress to preempt such a traditional exercise of the State's police power.

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[6] ERISA imposes both substantive requirements and procedural standards on pension plans, and although it also establishes some limited standards for welfare plans, "[i]t does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life*, 471 U.S. at 732.

D. Construed In Light Of The Presumption Against Preemption, New York's Generally Applicable Hospital Rate Regulations Do Not "Relate To" Employee Benefit Plans Within Section 514(a) And Are Not Preempted

In this case, the court of appeals held that three surcharges imposed on hospital rates as part of New York's comprehensive regulation of in-patient hospital rates are preempted under section 514(a).[7] Pet. App. 22-25. The

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[7] After holding that New York's 13% and 11% surcharges were preempted under section 514(a), the court of appeals held that these two surcharges were not saved from preemption under the insurance savings clause, section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Pet. App. 26-27. If, contrary to the argument here, this Court determines that the surcharges are preempted under section 514(a), *amici* adopt petitioners' argument that these two surcharges are properly viewed as insurance regulation and saved from preemption.

The court of appeals also held that the 9% surcharge on HMOs is preempted because "HMOs . . . do not engage in the 'business of insurance' as a matter of law." Pet. App. 29 n.6 (quoting opinion of district court); *see also id.* at 26 n.5. *Amici* submit that this conclusory holding was in error.

While New York has a separate statutory scheme for the regulation of HMOs which is partially, but not fully, integrated with its regulation of commercial insurers, the triggering of the ERISA "savings clause" is not conditioned upon a State's having fully integrated insurance regulation within a single statutory scheme. Many States have separate statutory schemes for HMOs which parallel and are significantly, but not totally, integrated with the States' insurance codes. These separate regulatory structures are designed to reflect operating characteristics of HMOs which differ from those of commercial insurance companies. Although set forth in separate statutory provisions, such state regulatory requirements for HMOs reflect the fact that the regulated function is the assumption of a third party's risk in return for a fixed payment—in other words, insurance. *See In re Estate of Medcare HMO*, 998 F.2d 436, 443-45 (7th Cir. 1993). Moreover, contrary to the assumption of the court of appeals, *see* Pet. App. 26 n.5, the functions of traditional commercial insurers and HMOs are not clearly distinct. Many commercial insurers provide coverage through managed care arrangements which deliver services through pro-

court found that the surcharges "relate to" employee health care benefit plans governed by ERISA because they "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" and "force ERISA plans to increase either plan costs or reduce plan benefits." *Id.* at 23-24.

In holding that the New York rate regulations are preempted simply because they have an indirect economic impact on ERISA plans, the court of appeals relied almost exclusively on this Court's general directive that section 514(a) should be construed broadly. *See* Pet. App. 20-21. The Second Circuit did not thoroughly review this Court's ERISA preemption cases; it did not justify its holding in terms of the policies served by ERISA's express preemption provision; and it completely ignored the presumption against preemption in determining the outer limits of the preemptive effect of section 514(a). *See* Pet. App. 19-25.

Amici adopt, without repeating, petitioners' arguments that the Second Circuit's extravagant reading of section 514(a) is inconsistent with this Court's ERISA preemption cases. *See also United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1191, 1193 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). Moreover, as petitioners explain, New York's hospital rate regulations are completely consistent with the purposes of ERISA preemption. The national interests in a uniform body of benefits law and in avoiding conflicting administrative directives are not implicated simply because the costs of hospital services, which vary for economic reasons from State to State, may also vary because some States have decided to control health care

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vider networks, as do HMOs. Furthermore, HMOs indemnify their insureds for 20% to 60% of covered expenses in addition to providing benefits through direct delivery of services. *See Estate of Medcare*, 998 F.2d at 446 (under Illinois law "HMOs are . . . the substantial equivalents of domestic insurance companies").

costs. *See United Wire*, 994 F.2d at 1194 (national interests in preemption not compromised by similar New Jersey hospital rate regulations).

The court of appeals' rule extends the preemptive effect of section 514(a) far beyond the bounds intended by Congress. The court of appeals failed to construe the express preemptive language of section 514(a) in light of the presumption against preemption.[8] Consequently, its judgment is an "unintended encroachment on the authority of the States." *CSX*, 113 S. Ct. at 1737. If left undisturbed, the court of appeals' judgment would displace important state health care regulations and initiatives, and it would cast a wide range of health care matters into a regulatory void—ungovernable by the States and ungoverned by the national government.

II. THE COURT OF APPEALS' STANDARD IMPAIRS THE STATES' ABILITY TO DEVISE SOLUTIONS TO SIGNIFICANT HEALTH CARE ISSUES AND CREATES A REGULATORY VOID

While health care reform has failed to materialize at the national level, the States have taken the lead "in devising strategies to expand access to health insurance and contain the growth of health care costs." U.S. General Accounting Office, GAO/HRD-92-70, *Access to Health Care: States Respond to Growing Crisis* 2 (June 1992). The States have attacked "[t]he problems of dwindling access to care and escalating health care costs" because "many state lawmakers . . . conclude[d] that it would be

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[8] In contrast to the Second Circuit, the Third Circuit took the presumption against preemption into account in upholding a set of New Jersey hospital rate regulations that are analogous to the regulations at issue in this case. *See United Wire*, 995 F.2d at 1196 ("[W]e are unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs."). The New Jersey rate regulation scheme was superseded by new legislation on January 1, 1993. *See id.* at 1190.

risky, if not irresponsible, to do nothing and hope that the Congress and the President [would] resolve the health care crisis." Intergovernmental Health Policy Project, The George Washington University, *Health Care Reform: 50 State Profiles* 1 (3d ed. 1994). *See generally id.* (comprehensive survey of current and proposed state efforts to control health care spending, improve quality of care, and expand access to medical care).

ERISA, however, imposes significant constraints on state reform efforts because vast numbers of Americans obtain health care benefits under ERISA plans.[9] *See generally* Patricia A. Butler, *Roadblock to Reform: ERISA Implications for State Health Care Initiatives* (National Governors' Association, 1994). Section 514(a) limits the States' power to implement health care reforms because it prohibits direct state regulation of the terms and conditions of health care plans. Under the "insurance savings" clause, 29 U.S.C. § 1144(b)(2)(A), ERISA does permit the States to achieve some health care reforms indirectly by regulating insurance. State insurance regulations, however, apply only to "insured plans" (ERISA plans that purchase insurance) and, under the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), state insurance regulations do not apply to "self-insured" ERISA plans. "[A]bout 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments." U.S. General Accounting Office, GAO/HRD-94-26, *Health Insurance Regulation: Wide Variation In States' Authority, Oversight, and Resources* 2 (Dec. 1993).

Amici recognize that ERISA places significant limitations on the States' power to reform their health care systems. The States have long undertaken the daunting task of health care reform with a full understanding of

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[9] The great majority of the almost 220 million Americans who have health insurance receive their benefits through public and private employer-sponsored health plans. U.S. Bureau of the Census, *Statistical Abstract of the United States* 118 (114th ed. 1994).

these limitations. *Amici* also recognize that many of these limitations must be addressed by Congress.[10] Nonetheless, the court of appeals' expansive interpretation of section 514(a) creates serious and unwarranted barriers to state regulation. *Amici* accordingly submit that affirmance of the decision below would preclude meaningful state health care reform, a result never intended by Congress.

A. The Court Of Appeals' Standard Preempts Traditional State Regulation Of Health Care

The court of appeals held that New York's hospital rate regulations are preempted under section 514(a) because they "substantially" or "significantly" increase costs of providing health care services for ERISA plan beneficiaries. Pet. App. 23-24. This ERISA preemption standard places many important state health care regulations and initiatives in jeopardy simply because they have an indirect economic effect on ERISA health care plans.

The court of appeals' rationale would require invalidation of state hospital rate regulation and prevent state experimentation with hospital rate regulation as a means of providing hospital care for indigent persons. Many States impose taxes on health care providers as a means of funding their share of medical care under the Medicaid program. The court of appeals' rationale would, however, prohibit these state taxes and deny the States the power to use taxes on health care providers as a component of their comprehensive health care reform programs. Finally, the decision calls into question a broad array of traditional state health care regulations, including licensing requirements for hospitals and physicians, for they, too,

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[10] Some limitations on the States' powers to reform health care are necessarily addressed by congressional amendments to ERISA. *See* 29 U.S.C. § 1144(b)(5) (exemption for Hawaii's law requiring employers to provide health insurance for full-time workers). Washington and Oregon have sought similar congressional relief. *See* H.R. 2870, 103d Cong., 1st Sess. (1993); H.R. 3618, 103d Cong., 1st Sess. (1993).

have the inevitable effect of increasing costs for ERISA plans.

These restrictions on the States' traditional police powers go to the heart of our federal system. The States have long served as laboratories for the exploration of alternative solutions to complex social and economic problems. In the oft-quoted words of Justice Brandeis,

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

In accordance with this tradition, States have long engaged in innovation in health care financing, delivery, and regulation. New Jersey, for example, pioneered the concept of paying hospitals on a per case or diagnosis related ("DRG") basis, a state innovation that preceded the federal Medicare program's "Prospective Payment System." *See* 1 *Medicare and Medicaid Guide* (CCH) ¶ 4200 (1993). Similarly, state laws requiring hospitals to provide emergency care to indigent persons predated the Medicare "anti-dumping" provisions of the 1986 Consolidated Omnibus Budget Reconciliation Act, Pub. L. No. 99-272 § 9121, 100 Stat. 82, 164-67, codified as amended at 42 U.S.C. § 1395dd. *See* Michael A. Dowell, *Indigent Access to the Emergency Room,* 18 Clearinghouse Review 483, 485 (1984). The court of appeals' holding severely compromises the States' ability to continue to explore innovative health care policies.

1. *State Power To Regulate Rates Charged By Hospitals And Other Health Care Providers*

States have experimented with hospital rate regulation for over thirty-five years. Frank A. Sloan, *Rate Regulation for Hospital Cost Control: Evidence from the Last Decade*, 61 Milbank Memorial Fund Quarterly 195, 197 (1983). While the States' programs have varied substantially in their details, mandatory rate-setting programs have reduced hospital and overall health care expenditures, improved hospital efficiency, diminished cross-subsidies across payors, and expanded access for people lacking health insurance. *See* Gerald F. Anderson, *All-Payer Rate-Setting: Down But Not Out*, Health Care Financing Review 35 (Supp. 1991). Today, in addition to New York, three other States—Maine, Maryland, and West Virginia —have mandatory hospital rate-setting laws.[11] The rationale of the court of appeals would lead to invalidation of these laws to the extent that they increase the costs of hospital services purchased by an ERISA plan.

The adverse impact of the court of appeals' preemption standard on the States' power to regulate health care through rate regulation is illustrated by considering hospital rate-setting as a means of financing "uncompensated care" for uninsured, low-income persons. The States of Maine, Maryland, West Virginia, and New York include the cost of each hospital's uncompensated care in the rates charged to all private payors, including ERISA plans.[12] These four schemes vary in detail, but share the goals of maintaining hospital solvency and ensuring equitable access to hospital care by spreading the cost of

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[11] Me. Rev. Stat. Ann. tit. 22, §§ 382(16-A), 396; Md. Health-Gen. Code Ann. §§ 19-216—19-219; W. Va. Code §§ 16-29B-19—16-29B-21.

[12] *See* Code of Maine Rules, 90-460, ch. 372; Md. Regs. Code tit. 10, § 10.37.10.03D; W.V. Code St. Reg. §§ 65-5-5.9.7—5.9.9; N.Y. Pub. Health Law § 2807-C(14); N.Y. Comp. Codes R. & Regs. tit. 10, § 86-1.65.

uncompensated care across all purchasers of hospital services.

The New York, Maine, Maryland, and West Virginia uncompensated care rate regulations are vulnerable under the rationale of the court of appeals. In each State, the cost of providing care to indigent persons will be passed on to all purchasers of hospital services, including ERISA plans. These increased costs will then force health care plans governed by ERISA either to increase plan costs or to reduce plan benefits. Under the reasoning of the court below, this indirect economic impact on ERISA plans is sufficient to preempt these traditional police power measures.[13]

In addition to circumscribing the States' power to regulate hospital rates, the court of appeals' decision could also be applied to preempt state rate regulation of other types of health care providers. For example, it could interfere substantially with proposals in Minnesota and other States to regulate rates charged by all health care providers. Minnesota, for example, has enacted a comprehensive health care act. *See Boyle v. Anderson*, 849 F. Supp. 1307, 1309 (D. Minn. 1994). Rate regulation is an integral part of this reform program, and the State will regulate rates paid to health care providers who are not part of integrated plans. Minn. Stat. Ann. §§ 62P.01-62P.05; *see* Commissioner, Minnesota Department of Health, *Implementation Plan and Recommendations for Integrated Service Networks and a Regulated All-Payer Option* 2 (Feb. 1994). State officials have determined that rate regulation of health care providers is necessary to implement an efficient and effective health care financing and delivery system, but the reasoning of the

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[13] New York's provisions for funding uncompensated care are the subject of a pending preemption challenge. *Trustees of the Pension, Hospitalization, and Benefit Plans v. Cuomo*, No. 92-CV-5589 (E.D.N.Y.).

court of appeals would preempt this exercise of state rate-setting authority to the extent that it imposes substantial costs on ERISA plans.

2. *State Power To Tax Health Care Providers*

Under the court of appeals' standard, section 514(a) could also prohibit state taxes on hospitals and other health care providers. Another panel of the Court of Appeals for the Second Circuit recently held that a 0.6% tax on the gross receipts of hospitals and other medical facilities is not *de minimis*. *NYSA-ILA Med. & Clinical Serv. Fund v. Axelrod*, 27 F.3d 823, 828 (2d Cir. 1994), *petition for cert. filed*, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745). In direct reliance on the reasoning of the court of appeals in this case, the panel held that the state tax was preempted because it increased the costs of providing health care to beneficiaries of ERISA plans. *Id.* at 827-28.

Most state taxes on health care providers are imposed under authority explicitly granted by Congress in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, codified at 42 U.S.C. 1396b (w).[14] Although these taxes are an important part of state efforts to fund their share of Medicaid costs, a federal court has already invoked the court of appeals' decision in this case to hold that a Connecticut hospital tax is pre-empted. *New England Health Care Employees' Union, District 1199 v. Mount Sinai Hosp.*, 846 F. Supp. 190, 192, 196-98 (D. Conn. 1994), *app. pending*, Nos. 94-7264, 94-7906 (2d Cir.).

In addition, Washington and Minnesota have established provider taxes as integral parts of their comprehensive health care reform programs. *See* Minn. Stat.

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[14] Many States impose taxes on hospitals under this statute. *See* Br. *Am. Cur.* State of Connecticut *et al.* at 18 n.9.

Ann. § 295.52; Wash. Rev. Code Ann. § 48.14.0201. A district court has held that the Minnesota tax on health care providers did not have a substantial economic impact on ERISA plans and rejected a preemption argument that was based on the opinion below in this case. *Boyle*, 849 F. Supp. at 1315-17. However, the economic impact standard may now be a significant barrier to this state tax because *Boyle* was decided before the Second Circuit concluded that there is no *de minimis* exception to its preemption standard. *Compare Boyle*, 849 F. Supp. at 116 *with NYSA-ILA*, 27 F.3d at 828.

3. *State Power To Set Health Care Standards*

Many traditional state health care regulations, like information reporting requirements and quality of care standards, increase costs of providing medical care. *See, e.g.*, Cal. Code Regs. tit. 22, §§ 70401-657 (setting standards for a wide range of specialized hospital services such as burn, cardiac surgery, and newborn care units); New Jersey Department of Health, *Licensing Standards for Hospitals* § 8:43G-17 (1993) (minimum nursing staff levels for hospitals). Hospitals, pharmacists, doctors, and other health care providers ordinarily pass these increased costs on to health care consumers, including participants in health care plans governed by ERISA. To the extent that these regulations "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," they, too, would be preempted under the court of appeals' reasoning.[16] Pet. App. 23.

State health care data reporting laws illustrate that there is no apparent stopping point to the court of appeals' theory of preemption based on indirect adverse economic impact. Many States have enacted laws requiring health care providers to report information such as "type of services provided, charges, patient information

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[16] Indeed, the subsequent opinion of the court of appeals in *NYSA-ILA* suggests that substantiality may no longer be an issue in the Second Circuit. *See* 27 F.3d at 827-28.

and outcomes, and type of insurance coverage." *Health Care Reform: 50 State Profiles*, at 15. These data collection laws "play a key role in [States'] cost containment and reform initiatives." *Id.* Nevertheless, collecting, analyzing, and reporting information may impose substantial, if not easily quantifiable, costs on health care providers, and the parties subject to these data reporting requirements may well try to pass the costs of compliance on to ERISA plans and other health care consumers. A recent attack on the data reporting requirements of Minnesota's new health care reform act suggests that concerns about the impact of the court of appeals' preemption standard on traditional state health care regulations are not unwarranted. *See Boyle*, 849 F. Supp. at 1311-12.

B. Preemption Of Traditional Police Power Regulations Will Leave Important Health Care Matters Ungovernable By The States And Ungoverned At The National Level

Carried to its logical conclusion, the reasoning of the court of appeals would give rise to a regulatory void. As shown above, the court of appeals' decision has already led to legal challenges asserting that section 514(a) preempts the States' power to regulate hospital rates and to provide charitable or "uncompensated" medical care for indigent persons. Moreover, if left to stand, the court of appeals' interpretation of section 514(a) will undoubtedly prompt additional challenges to other exercises of the States' traditional power to regulate health care. This expansive judicial interpretation of section 514(a)'s preemptive effect is particularly troubling because ERISA makes no provision for substantive regulation of employer health plans.[16]

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[16] *See Health Care Reform: 50 State Profiles*, at 3 n.1 ("Although ERISA preempts state regulation, there is no parallel federal regulation of employer health plans at this time.").

Given Congress' long-standing inability to enact comprehensive federal health care regulation, the Court should reject any interpretation of section 514(a) that would lead to the creation of a regulatory void.[17] In a closely analogous case, the Court interpreted several statutory provisions explicitly allocating regulatory authority between the States and a federal regulatory agency in order to avoid creating a regulatory void and to preserve from preemption a traditional area of state regulation. *Pacific Gas & Electric Co. v. State Energy Resources Conservation & Development Comm'n*, 461 U.S. 190 (1983). The Court first found that the Atomic Energy Acts of 1946 and 1954 gave the national government exclusive authority over radiological safety standards for commercial nuclear power plants and that Congress had left "no role . . . for the States." 461 U.S. at 206-07. After noting that Congress had not given the national government any authority over the economic aspects of nuclear power generation, the Court, in keeping with the presumption against preemption, concluded that the States must retain this type of regulatory authority because "[i]t is almost inconceivable that Congress would have left a regulatory vacuum." *Id.* at 207-08.

Although the Court found that this interpretation of the statute was reinforced by other sections of the statute expressly saving state authority, *see id.* at 208-12, it construed the national government's exclusive power over radiological safety narrowly for the specific purpose of preserving the States' traditional power to regulate the economic aspects of the operation of electric utilities.

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[17] This Court has consistently rejected any interpretation of federal law that could create a regulatory void. For example, the Court has often refused to hold that state law remedies are preempted where federal law provides no comparable or alternative remedy. *See, e.g., Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984); *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656, 663-64 (1954); *see also Cipollone*, 112 S. Ct. at 2630 (Blackmun, J., concurring in part and dissenting in part).

Indeed, the principle of avoiding a regulatory vacuum with regard to the economic aspects of nuclear power plant construction was so important that the Court was willing to tolerate some risk that the States would exercise their authority over economic matters to accomplish radiological safety objectives that are the exclusive responsibility of the national government. *Cf. Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 256 (1984) (noting "tension between the conclusion that safety regulation is the exclusive concern of the federal law and the conclusion that a State may nevertheless award damages based on its own law of liability").

State regulation of health care is at least as important as state regulation of the economic aspects of electric power generation. There is no reason why this Court should construe section 514(a) to create a regulatory vacuum with regard to important health care issues. A narrow construction of section 514(a) is required by the presumption against preemption. It is also consistent with this Court's cases holding that state laws are superseded where "the bite of pre-emption" has been eased by congressional provision of a substitute for the pre-empted state laws. *Cipollone*, 112 S. Ct. at 2630 (Blackmun, J., concurring in part and dissenting in part); *see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990) (comprehensive federal civil enforcement scheme fills void created by preemption of state common law claim); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-56 (1987) (same); *see also Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988) (preemption of one state garnishment law does not create a regulatory void because a second state garnishment law is not preempted).

In this case, there are no substitute national regulations to fill the void that is created by the court of appeals' construction of section 514(a). There is no basis for believing that Congress, in enacting ERISA, intended to

leave hospital rates, doctors' fees, medical care for indigent persons, and similarly vital health care matters ungoverned until such indefinite time in the future that Congress chooses to fill the regulatory void. Although there undoubtedly are some adjustments of state and national power that require congressional attention, it would stand the presumption against preemption of traditional state police powers on its head to insist that the States must overcome the inertia of the national legislative process and secure statutory relief from the court of appeals' interpretation of section 514(a). To the contrary, the burden should be on Congress to make an explicit decision displacing the States' traditional power to regulate the delivery of health care. Congress did not make that decision in the language of section 514(a).

CONCLUSION

The judgment of the court of appeals should be reversed.

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